Transforming Child Protective Services in New Jersey

DYFS Transformation Plan

Submitted to
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PeopleFIRST
NJ Department of Human Services

INTRODUCTION:

This report outlines the Department of Human Services' plan to stabilize the state's child protection system, specifically the Division of Youth and Family Services (DYFS), and to map out a longer term strategy for systemic reform across all child-serving programs.

This plan emphasizes the critical issue of decision making as it relates to the delivery of vital children's services. Throughout the Department's review of the Faheem Williams case and of the DYFS system as a whole, the issue of how, when and why decisions were made was a central focus.

This report recognizes that it is the decisions that we make on behalf of vulnerable children - whether it is to remove a child from the home, or to recommend substance abuse treatment for a parent -- upon which the success of our intervention turns. Similarly, this plan recognizes the need to provide the appropriate structure and support for good decision making.

Background

On January 5, 2003 the entire state of New Jersey and, indeed, the entire nation, was stunned by the news that the mummified body of a seven-year-old boy was found in a rubber storage container in the basement of a Newark home -- the same basement in which the boy's twin and baby brothers had been found, emaciated and starving, the previous day.

The world would soon learn that these boys had, at various points in their lives, been under the supervision of New Jersey's child protection agency, the Division of Youth and Family Services. Indeed, it would soon be learned that DYFS had case files on the family's history dating back some ten years and that allegations of abuse or neglect had been levied against the boy's mother and other caretakers 11 times.

But perhaps the most shocking disclosure came when it was learned that DYFS workers had actually closed the agency's case file on this family -- despite a relative's allegation, never fully investigated, that the children were being beaten and burned.

The circumstances surrounding the death of Faheem Williams were tragic, shocking and horrific and uncovered terrible flaws in the government systems designed to keep children safe.

We must do better. And we must make sure that the death of the child Faheem is not in vain. In his memory, we must improve the systems that serve children immediately, and we must sow the seeds of lasting change as well.

The Williams case:

The indepth review of the Williams case that followed the death of Faheem has revealed a family with multiple problems.

Over a 10-year period, the family was the subject of a series of allegations of abuse/neglect and family problems. The pattern of allegations included lack of supervision, substance abuse and sale from the home, physical abuse, and physical neglect including, but not limited to, deplorable living conditions and lack of food.

Despite this litany of complaints, the Williams family case record is absent any documentation that would indicate allegations were investigated in the context of the family history. Indeed, not only were allegations investigated in isolation, but many investigations by caseworkers were superficial and lacked collateral contacts to verify information provided by the family. This incident driven approach to case management severely crippled any meaningful attempt to work with the family.

There were other deficiencies as well: the children were not visited by a DYFS worker for months at a time, despite an expectation that monthly visits would be made; drug treatment referrals were made but not enforced, despite notations of suspected drug abuse; and, finally, the case was closed with an uninvestigated allegation of abuse.

With all of this noted by its inclusion or absence from the case file, there was no documented review by an upper level supervisor or manager to correct the course of case intervention. Which begs the question: to what extent did the casework staff believe that their efforts were acceptable to the supervisors to whom they reported? To what extent did the hands off supervisory behavior give tacit approval to sloppy work and fail to hold anyone accountable until Faheem's death?

The Immediate Aftermath: A State of Emergency

In an effort to immediately address some of the issues raised by the Williams case, I declared a state of emergency in DYFS that forbade caseworkers in local district offices from closing any case where a child had not been seen.

I also ordered an immediate accounting of all of the cases statewide where a child had not been located yet an open allegation of abuse existed. As a result, it was determined on January 8 that some 280 allegations remained open and uninvestigated.

Today, the number of open allegations where children have not been located is 10. For the 10 allegations that have not been completed, DYFS and law enforcement officials have determined that not enough information is available to investigate further. For instance, in some of the remaining allegations, referents did not identify the children by name and some of the addresses provided were vacant lots or abandoned buildings. I have been assured that every possible measure has been taken to investigate these allegations and that they all have been conferenced with the Attorney General's Office.

I have also ordered an additional layer of review in those cases where a caseworker has seen the children and has been working with the family and plans to move to close the case. In those situations where we have worked with the family and can certify that the children are safe, I will allow a case to be closed only if a high level supervisor in the district office has reviewed the case and personally signed off on approving the closure.

Finally, I took immediate disciplinary action against the caseworker and the frontline supervisor who closed the Williams children's case in February 2003 without having fully investigated an open allegation of abuse.

In the Aftermath: Continued Fact Finding

For the purposes of understanding the operation of DYFS, it is important to understand the structure of the local DYFS field offices, called District Offices. Each District Office is located within one of four service regions: Southern, Central, Metro and Northern. A Regional Assistant Director heads each region.

A District Office Manager who supervises one or more Casework Supervisors heads each of the division's 32 District Offices and reports to a Regional Assistant Director. The District Office Manager and the Casework Supervisors are considered upper level management within the District Office. The Casework Supervisors manage frontline supervisors, or Supervising Family Service Specialists, who direct the activities of a unit of caseworkers or Family Service Specialists. The caseworkers investigate child abuse and neglect investigations and manage an ongoing caseload of families and children (This reflects only direct service staff, not Adoption Resource Centers).

In the wake of this terrible incident, the Department sought input from District Office staff at every level as well as from a wide variety of stakeholders in the realm of child protection, including the unions representing DYFS staff and key advocates. This fact finding process revealed some weaknesses in the state's child protection system.

1. The Mission of DYFS is too broad

Over time, the vision and mission of DYFS have been interpreted in such a way as to place far too varied and disparate a range of responsibilities -- such as serving as the principal point of contact for the juvenile justice system or providing residential treatment for youth with emotional and behavioral problems -- on a single agency.

2. The DHS service delivery system for children is fragmented

The Department has dozens of programs that serve children housed within nearly every operational and functional area. Services for children -- including protective services, behavioral health treatment, health services, early intervention services, child support and many other functions -- occur with too little cross-pollination or coordination.

3. Caseworker supervision is inadequate

There appears to be a lack of supervisory checks and balances within the DYFS system. Cases considered non-emergent by frontline staff are rarely conferenced with upper level supervisors. Case closing decisions are routinely made exclusively by the caseworker and frontline supervisor, without the upper level supervisor's review.

4. The workforce is inexperienced

The vast majority of the DYFS frontline workforce has less than five years experience. In fact, 80 percent of direct care staff (caseworkers, frontline supervisors and Casework Supervisors) has less than five years experience, and 25 percent of the casework staff are trainees with less than one year of experience.

5. DYFS lacks the sufficient and required tools to support staff

- ***Supervision*** -- Caseworkers need to have access to well trained supervisors and Case Practice Specialists who can direct and assist them.

- ***Updated Technology*** -- The DYFS mainframe system utilized for tracking child abuse and neglect referrals is outdated and relies on technology that is at least 20 years old. Casework staff use paperbased tracking systems.

- ***Equipment*** -- DYFS workers do not have enough cell phones, working computers, cameras and cars to do their jobs properly, which puts them in the position of waiting for equipment in order to respond to case management issues.

- ***Training*** -- Training at DYFS has focused primarily on new worker training. Supervisory training has been pushed to the back burner. Frontline workers need the support of supervisors who have been trained to have broad knowledge of child protection as well as the ability to lead, manage and monitor performance.

- ***Worker Safety*** - The harsh reality is that many child protection workers are forced to walk into confrontational situations with families, sometimes in some of the state's worst, most dangerous neighborhoods. Caseworkers need more backup from local law enforcement entities when entering a dangerous situation and need greater security in local field offices.

6. There is a lack of accountability across the system

As evidenced by the Williams case, there are currently no adequate tools -- including information systems -- available to hold upper level supervisory staff and managers accountable for decisions made by their staff. Moreover, Casework Supervisors are not required to randomly review cases; they only review those cases that are specifically brought to their attention by lower level staff.

7. Caseloads vary in size and complexity

The numbers of cases that a worker carries can vary widely. While the average is about 33 cases per worker, with each child considered a case, or about 18 families, there are clearly caseworkers who are overburdened and many caseworkers complain they feel pressured to close cases.

Of equally critical concern is the random nature of case assignment, which fails to consider the complexity of a case. Nor does it take into account the fact that all caseworkers spend hours performing tasks ancillary to their core function, such as providing transportation or waiting hours in family court.

A Clear-Cut Case for Sweeping Changes

This tragedy has illuminated two major and longstanding issues within the state's child protection system:

1.) The function of DYFS is too broadly defined. As a result, the agency needs to be completely restructured and the child protection function -- which is its core mission -- given its own organizational heartbeat. To that end, I am recommending that DYFS, as we know it, be reconstituted and that a division solely dedicated to child protection and child permanency be created.

In short, the goal is not simply to reform DYFS, but to transform it.

2.) While government has the prime responsibility for child welfare, the issue of the health and safety of children and families requires the commitment and participation of the larger community -- government alone cannot accomplish this goal.

The action steps outlined herein are informed by those two realities and focus primarily on:

- The need to stabilize DYFS to ensure safety and to rebuild public confidence in the state's child protection system as we prepare to transform it.

- The need to implement sweeping and meaningful, long term changes in the systems that serve children in this state to ensure coordination and integration of all other children's services.

A Plan for Stabilization and Longterm Change

Immediate stabilization efforts

1. Centralize children's services - with community input and responsibility

A new child protection division, called the Division of Child Protection and Permanency (DCPP), will report to a new Deputy Commissioner within the Department. Within six months, this new Deputy Commissioner will devise a plan to consolidate the management of most, if not all, other children's services currently housed within the Department of Human Services.

This recommendation heeds the advice of advocates who have expressed concern that children's services are fragmented and children do not receive the priority attention they deserve while, at the same time, not creating another layer of bureaucracy.

While child protection will be housed within a newly created division, it is still important to ensure that children's services are coordinated adequately within the Department.

Specifically, the new Deputy Commissioner will be called upon to create another organizational unit to be responsible for children with behavioral health needs. This operational unit would take on all the children currently under DYFS supervision in residential treatment as well as:

- The three DYFS residential treatment centers,
- The Children's System of Care Initiative (The Partnership for Children)
- The Office of Children's Services from the Division of Mental Health Services

Additionally, other Department-based children's services will be considered for transfer to the new Deputy Commissioner's portfolio including, but not limited to:

- The Kinship Care Program
- The Office of Education
- The Child Support Program from the Division of Family Development

The Deputy Commissioner will fashion this new organizational structure with input from a wide variety of community partners and will be charged with emphasizing the role and responsibility of those partners in effecting meaningful change.

2. Increase Resources

The proposed State Fiscal Year 2004 budget includes a nearly $14.3 million increase for new staff and equipment for DYFS to allow caseworkers to focus on case work, to stabilize the present situation and to help lay the groundwork for the system change that must necessarily follow. The influx of funding will pay for:

- 112 direct care staff, including supervisors and caseworkers
- 127 support staff, including Case Practice Specialists, nurses, case aides, transportation aides, interpreters and
- 32 Human Services Police officers to link with local law enforcement, to improve worker safety and to assist in locating families
- 2,700 more computers
- 2,000 cell phones

In addition, $5.6 million has been set aside in the Department's capital budget to pay for the implementation of the Statewide Automated Child Welfare Information System (SACWIS).

3. Change policy and practice

The Department will also move immediately to change practices in DYFS that can be immediately addressed through better management, increased training and greater emphasis on accountability.

Increase accountability

Continue and expand case audits, demand managerial accountability

The Department will continue to audit the cases handled by the employees who have been disciplined in the Williams case and will audit a sample of closed cases in the Newark District Office II, as well as a statewide sample.

In addition, the Department will hire an independent outside agency to implement an aggressive auditing program (called Quality Service Reviews -- QSR) that involves a random review of DYFS case files. These audits will be outcome and performance based, involving not just case file reviews but also interviews with clients, service providers and other systems (like the courts, schools etc).

Using the QSR methodology, the Department can gauge such performance based measures as: how often children placed into foster care receive appropriate medical and psychological evaluations, or the quality and frequency of contacts with children under supervision. These reviews serve the dual purpose of flagging poor quality and providing a base line assessment upon which future comparisons can be made.

Any deficiencies uncovered through these audits will require the development of a corrective action plan, which will be implemented by DYFS but monitored by the Department's Office of Program Integrity and Accountability (OPIA). OPIA will issue internal report cards directly to the Commissioner on the status and effectiveness of remediation plans.

In addition, DYFS quality assurance staff will be increased by five and trained in the service review protocols. In this way, this tool can be used routinely to monitor quality and to measure progress. DYFS senior managers will have the objective tools they need to measure and monitor performance at the local district office level. As such, Regional Assistant Directors, District Office Managers, Casework Supervisors and other senior managers will be held accountable for the case practice activity and decisions made by their staff.

Revise management expectations

You cannot advance organizational change without leadership. To lead, one must understand an organization's strengths and weaknesses and have a clear vision for the future.

To this end, the Department has already taken steps to link with national public welfare and child welfare organizations to diagnose the District Office operations within DYFS and to develop leadership training that will be required for every District Office Manager in the DYFS system.

We will also consider elevating the District Office Manager position to the Senior Executive Services to maximize our capacity to attract the best managers for the offices, skilled in both case practice and organizational management.

Enhance recruitment, retention and selection processes

Attracting and keeping skilled and compassionate frontline staff is a major challenge in the child welfare field, both here in New Jersey and nationally.

To address this issue, the Department will hire a recruiter to review hiring and promotion practices to encourage experienced staff to continue working in the field. Efforts in this area will also focus on creating a way for existing Department staff to transition into or out of the child welfare system, where appropriate.

Expand and mandate training

Mandatory training for all supervisors and managers will be developed using the best national standards available and will focus on performance management skills, ongoing leadership development, quality improvement techniques and an understanding of emerging trends in child protection.

Strengthen supervision, teamwork and case practice

Current policy, procedures and staffing allocation in DYFS allow too many case decisions regarding children to be made exclusively by frontline supervisors and caseworkers. This could unintentionally foster an environment of "don't ask - don't tell." If the Casework Supervisor does not ask about problems with a family and the frontline staff do not tell about problems with that family, it could be assumed that no problem exists. Errors of omission such as this can lead to tragic consequences.

The addition of 112 direct care staff in SFY 2004 -- 47 of these will be supervisors -- will make it possible for supervisory spans of control to be reduced, increasing the ability of supervisors to oversee case handling.

Currently, the average Casework Supervisor supervises 4.3 frontline supervisors. The addition of new Casework Supervisors in SFY '04 will reduce that ratio to 1:2.8.

In addition, each District Office will have access to at least one Case Practice Specialist -- reporting directly to the District Office Manager -- who will consult on cases along with supervisors. Although Case Practice Specialists are not factored into supervisory ratios, they can provide an additional level of consultation and quality review.

Expand team approaches

The Department will also consider the use of team supervision models, where cases are assigned to teams as well as to individual workers. Team supervision and case handling features intensive involvement of Casework Supervisors, Case Practice Specialists, frontline supervisors and frontline caseworkers and trainees. These teams review cases together and respond to families creating mutual and multi-level accountability. The involvement of higher level, more experienced staff reinforces caseworker and supervisory training and enhances skill levels. Thus, new workers and supervisors are effectively mentored by more experienced staff knowledgeable about appropriate case practice.

Clarify and strengthen decision making

The Department will expedite implementation and development of a Structured Decision Making (SDM) model for use by child protective workers and supervisors. Some of this already exists but, unfortunately, none of it is automated. Under this model, workers are prompted to:

- make collateral checks on the family being investigated, including previous DYFS history, by using a screening assessment;
- use a uniform checklist to certify immediate safety as part of a safety assessment;
- gauge the possibility of future child maltreatment, through the use of a risk assessment.

Caseworkers will have access to an actuarial as well as a consensus assessment of the family when making case practice decisions. With a fully implemented and automated decision support system, cases could be "weighted," based on complexity to aid in caseload assignment.

Expedite SACWIS -- improve Information technology

In order to automate Structured Decision Making and to address the pressing information technology needs of the entire child protective system, plans for the implementation of a Statewide Automated Child Welfare Information System (SACWIS) have been expedited and additional funds have been included in the SFY 2003 and SFY 2004 budgets.

In SFY 2004, $5.6 million has been earmarked to expedite the implementation of SACWIS and the automation of SDM. This includes the purchase of equipment and software development.

Although SACWIS is a multi-year initiative, the safety and risk assessment protocols, as well as the screening assessment, will be automated through an interim web-based system. These interim tools will be developed as part of the ramp up to implementation of SACWIS and will be accessible to caseworkers by October.

The interim system will improve case management by providing casework staff with the ability to electronically record narrative information about their actual and attempted contacts with their clients. When fully operational, SACWIS will provide frontline staff with a comprehensive case management tool and will allow supervisors to monitor critical indicators, such as caseload size and caseload complexity.

Reduce caseloads and consider caseload complexity

Caseload size is an issue that has commanded a lot of attention in recent years as advocates, national child welfare organizations, union officials and casework staff all have differed on appropriate caseload size standards.

While the Department is not prepared at this time to provide a definitive statement about the optimal caseload size, we eagerly await the findings of a Staffing Outcomes and Review Panel, comprised of advocates, union leaders, legislators, court officials and Department staff, which will issue a report over the next few months on this issue.

In the interim, the Department will continue its commitment relative to increasing staffing levels as outlined in this report.

We are going to focus our efforts, as well, on creating a mechanism for assigning cases based on their complexity rather than relying on a rotation system based solely on numbers. This will be accomplished through information system enhancements and more hands on management of cases by higher level managers in the District Offices.

Still, there is a recognition that caseloads for some workers are well beyond acceptable levels, and an effort is under way to control large caseloads.

To address this issue, an early warning system has been implemented that requires managers and supervisors to report to the Department when a worker's caseload rises above 50. In addition, the District Office Manager must develop a corrective action plan with the worker -- which could include desk duty and job shadowing by a supervisor or a redistribution of cases -- to keep caseloads within an appropriate range. The message remains clear, however: No case should be closed unless fully conferenced with an upper level supervisor. And no case should ever be closed with an unresolved open allegation of abuse.

The addition of 127 support staff -- such as transportation aides, case aides and paralegals -- to perform such functions as transporting children to doctors appointments or preparing cases for court proceedings -- will free up caseworkers to perform critical case work functions.

Ensure worker safety

The Department will redouble its efforts to ensure the safety of caseworkers by increasing the number of Human Services Police officers assigned to DYFS. The Department will also convene a summit of community and law enforcement officials to explore ways to provide more support and back-up to workers.

Encourage worker input

The Department recognizes the need for frontline workers to have a way to provide input on the effectiveness -- or lack thereof -- of reform efforts. To that end, the department will develop within the child protection and permanency division a mechanism to facilitate an ongoing and dynamic communication process that encourages honest feedback to and from all levels of the division and the Department.

The Big Picture: Longterm Change

Enhance intradepartmental collaboration

The above measures will help to bridge the gaps in the current system. However, longterm and meaningful reform can only occur if there is a recognition that it is long past time for government and for society as a whole to view the needs of our children holistically.

The consolidation of authority and accountability for children's services, under the leadership of one person, enhances the ability for divisions and offices within the Department to communicate and collaborate with each other and sets the tone for the type of collaboration that will be essential to move the change process forward among all of our partners.

At the same time, we recognize that not all of the services provided by the Department are children's services, per se. It is for that reason that the need for intradepartmental cooperation and collaboration is so acute.

Specifically, as it relates to the child protection system, the Department has begun the process of enhancing intradepartmental coordination between DYFS and the Division of Family Development, which administers welfare. This recognizes the fact that a high percentage of longterm adult welfare recipients are also involved with the child protection system as parents. A similar collaboration between Medicaid and DYFS is currently under way to facilitate greater access to health care for children touched by the child protection system.

Additionally, the child protection agency will seek to expand family group conferencing statewide. Under this approach, extended family, educators, medical staff, family advocates, prosecutors, therapists and service agencies are required to meet with parents or caregivers to develop a team contract in which all members are accountable to each other and to the family. To the extent that many of the partners who will participate in this process implement Departmental programs, this initiative underscores a better intradepartmental as well as interdepartmental approach.

Enhance interdepartmental collaboration

Clearly, the job of keeping children safe and families whole is not solely the responsibility of the Department of Human Services -- it is the responsibility of the entire state of New Jersey.

The Williams case has raised some significant issues relative to communication and coordination -- or the lack of them -- among the many governmental and non-governmental agencies that touch the lives of troubled families.

As part of this transformation initiative, the Department will work with key state Departments to better coordinate the state's efforts on behalf of children.

Certain partnerships will provide an opportunity to revisit recommendations made in the 1998 report by the Governor's Blue Ribbon Panel on Child Protection Services. These collaborative partnerships with the Administrative Office of the Courts and the Departments of Education, Health and Senior Services, and Law and Public Safety will be ongoing in order to ensure systemic changes that extend beyond the tenure of any administration.

Today, the Department has already taken steps to forge partnerships with:

1. The Department of Health and Senior Services to bolster training of health care workers to identify abuse and develop better protocols for joint investigation, treatment and case planning.

2. The Administrative Office of the Courts (AOC) and the Attorney General to review and modify, where necessary, practices and guidelines regarding incarceration of individuals with dependent children, as well as information sharing when individuals may have been convicted of child endangerment involving unrelated children.

3. The Attorney General's Office to expand the number of deputy attorneys general (DAGs) assigned to provide legal representation for child abuse and neglect cases. This will enable the state to post DAGs in field offices so that frontline staff can have more direct access to legal counsel and can seek court orders for investigations, supervision or custody. The Attorney General's Office will also, hopefully, facilitate collaboration with local law enforcement. Additionally, the department will work with the AOC and the Attorney General's Office to foster stronger working relationships with the courts and the DAGs to more effectively utilize child protection staff in court proceedings.

4. The Department of Education to develop a procedure for the child protection agency to improve communication regarding the identification of children at risk from child abuse and neglect -- particularly as they relate to patterns of absenteeism among school-aged children.

Under the direction and the leadership of Governor McGreevey, I am confident that our sister Departments will join with us to ensure that we all do all we can do to keep children safe from harm.

A Concerted, Collective Effort

While the Department of Human Services and the state Departments responsible for children can certainly coordinate and collaborate better to help children, that isn't the end of the story.

It is necessary, as part of our efforts to prevent child abuse, to enlarge the discussion of child and family issues to include society as a whole.

Far too many communities have families with parents who are unable to parent, nurture or properly care for children. Often impoverished and with poor or nonexistent familial and social networks, these parents lack adequate support systems and parenting role models.

There are some things that government can and should do in this regard. But government cannot do everything.

I have convened a high level work group which includes representation from the Rutgers School of Social Work, the foundation community and community agencies, to begin a discussion on the pervasive nature of child abuse, as well as the role of the larger community in preventing this scourge.

This is, by necessity, a small group that will examine, review, and select best practices for communities across the state. It is my hope and expectation that this group's recommendations will provide a springboard to galvanize community ownership of child abuse prevention.

This workgroup will focus specifically on strategies for communities to:

1) teach individuals who have had no appropriate or healthy parent role model about effective parenting, and

2) provide a mechanism for children and other family members without healthy support systems to seek assistance before child abuse and neglect occur.

In order to develop a blueprint for change, the work group will engage national and local resources, such as, the Children's Defense Fund, the National Black Child Development Institute, the Association for Children of New Jersey and the University of Medicine and Dentistry of New Jersey's (UMDNJ), to facilitate this effort.

As we move forward with this process, which I recognize will take some time, I feel the need to establish an immediate safety valve, if you will, for children and families who need somewhere to turn for support and assistance in a crisis. To do this, the Department will establish -- in conjunction with the University of Medicine and Dentistry of New Jersey-affiliated University Behavioral Healthcare -- a statewide, toll-free "warm line" for New Jersey families to call to receive immediate support from clinical professionals and referrals to appropriate services.

CONCLUSION

Clearly, this Department has no greater responsibility than the protection and care of vulnerable children. The strategies and action steps cited above will stabilize the current system and begin to address structural issues that will lead to fundamental institutional reform at the Department of Human Services.

Despite a difficult budget year, Governor McGreevey clearly understands the emergent nature of the situation at hand in our child protection system. While many valuable programs throughout state government and within this Department have had to be curtailed, the commitment to the child protection system is strong with an additional $20 million budgetary commitment in SFY 2004.

But the Governor shares my view that more workers, more phones and more cars alone won't save our children.

We must ask ourselves: Who will teach the children of hopelessness, poverty and despair to love themselves and to envision a brighter future? Who will teach the children of abuse and deprivation how to love and care for their children?

Who will make children a priority?

None of what is being proposed can happen without broad-based support and active participation of the larger community. We must all feel free to provide input to shape this plan. And we must all accept and understand our solemn responsibility to see it through.

Also, we must all acknowledge that this plan addresses only the decision making and system coordination deficiencies highlighted by the tragic Faheem Williams case. It will take an even greater effort to address the broader issues that put our children at risk. But we must make that great effort and we must stay committed to that goal. For, until and unless we can find a way to rebuild a collective sense of responsibility for children and families throughout our communities, children will remain at risk. And those of us who are charged with leading this change effort will have failed to give meaning to the death of Faheem Williams.

DYFS District Office Structure*